STATE MEDICAID MANAGED CARE

REQUIREMENTS FOR LINGUISTICALLY APPROPRIATE HEALTH CARE

A Report by :

Association of Asian Pacific Community Health Organizations

Funded by the Bureau of Primary Health Care
through the National Association
of Community Health Centers

JANUARY 1996

STATE MEDICAID MANAGED CARE

REQUIREMENTS FOR LINGUISTICALLY APPROPRIATE HEALTH CARE

A Report by :

Association of Asian Pacific Community Health Organizations

Funded by the Bureau of Primary Health Care
through the National Association
of Community Health Centers

JANUARY 1996

Acknowledgments

This report was prepared by Purvi Mody Kunwar, M.P.H. and Ying Ying Meng, Dr.P.H.

This publication was supported by grant # CSH000009-11-0 from the Bureau of Primary Health Care through the National Association of Community Health Organizations.

AAPCHO would like to recognize the following individuals for their contributions: Freda Mitchem, NACHC; Yvonne Bice, NACHC; Art Chen, MD, Asian Health Services; Poncho Chang, Kaiser Family Foundation; Stephen P. Jiang, AAPCHO; Melissa Woods, AAPCHO; Chantal Raymer, AAPCHO; Darryl Tom, AAPCHO.

AAPCHO would also like to recognize the individuals at the State Medicaid managed care offices (see Appendix A for contacts) in the surveyed states for their valuable contributions without which this report would not have been possible.

Suggested Citation:

Association of Asian Pacific Community Health Organizations. "State Medicaid Managed Care: Requirements for Linguistically Appropriate Health Care". Oakland, California. January, 1996.

Association of Asian Pacific Community Health Organizations
1212 Broadway, Suite 730
Oakland, CA 94612
voice : (510) 272-9536
facsimile : (510) 272-0817

TABLE OF CONTENTS

EXECUTIVE SUMMARY

In response to cost and access problems associated with the delivery of health care to Medicaid beneficiaries, states have increasingly turned to managed care delivery systems to serve this population. In many states, moving Medicaid recipients into managed care plans has raised concerns regarding appropriate access to services, especially for underserved populations such as the non-English-speaking and limited-English-proficient, the homeless and people with HIV. The impact of managed care on these populations has yet to be determined.

The provision of quality, culturally appropriate health care is intimately related to effective communication between patient and health care provider. According to the 1990 Census, almost 14 million people living in the United States do not have strong English language skills. Medicaid recipients who are non-English-speaking or limited-English-proficient may have difficulties finding providers who speak their language and who are sensitive to their cultural attitudes or beliefs about health care. High rates of linguistically isolation in the states surveyed by AAPCHO indicate the need for linguistically accessible health services, especially in areas with high concentrations of immigrant populations.

This report addresses the issue of managed care and its potential impact on Medicaid recipients who are non-English-speaking or limited-English-proficient. To study state Medicaid managed care requirements for linguistically appropriate health care, the Association of Asian Pacific Community Health Organizations (AAPCHO) conducted a survey of 10 states with high numbers of limited-English-speaking households, reviewed documentation describing the states' policies for reducing language barriers and reviewed existing literature on the provision of linguistically appropriate health care to Medicaid recipients. The 10 states surveyed by AAPCHO were : California, Hawaii, Illinois, Massachusetts, Minnesota, New Mexico, New York, Oregon, Texas and Washington.

Most of the states surveyed by AAPCHO have begun addressing the issue of linguistic barriers to health care to varying degrees. Some states have set threshold levels before managed care plans have to provide linguistically appropriate health care while others require managed care plans to provide linguistically appropriate health care to all enrollees. States surveyed also vary in terms of how they monitor whether managed care plans are complying with state regulations. Compensation for managed care plans and providers for the provision of linguistically appropriate health care to Medicaid enrollees has begun in a few states.

Survey results highlighted the lack of uniform standards and guidelines for providing linguistically appropriate health care across the states. Results also underscored the need to establish a Medicaid managed care clearing house at the national level to encourage the exchange of information between states. Recommendations based on the results of the AAPCHO survey and review of literature were made for improving the delivery of linguistically appropriate health care to Medicaid beneficiaries enrolled in managed care plans. It is hoped this report will help identify innovative ways of delivering linguistically appropriate health care services to Medicaid enrollees under managed care.

State Medicaid Managed Care Requirements for Linguistically Appropriate Health Care

Chapter 1 Introduction

❖ 1.1 *Purpose of the Study*

In response to cost and access problems associated with the delivery of health care to Medicaid beneficiaries, states have increasingly turned to managed care delivery systems to serve this population.[1] The move towards managed care for Medicaid populations can exacerbate the barriers to access faced by ethnically and culturally diverse populations across the United States. Culturally appropriate services effectively identify the health practices and behaviors of target populations to design programs, interventions, and services which effectively address cultural and language barriers to the delivery of appropriate and necessary health care services.[2] The provision of quality, culturally appropriate health care is intimately related to effective communication between patient and health care provider. Those who have limited-English-proficiency face acute barriers to communicating with health care providers and accessing appropriate health care. Medicaid recipients who are non-English-speaking or limited-English-proficient may have difficulties finding providers who speak their language and who are sensitive to their cultural attitudes or beliefs about health care.[3]

Prior to the implementation of Medicaid managed care, non-English-speaking and limited-English-proficient Medicaid recipients had a choice of providers who could provide them with linguistically and culturally appropriate health care services. As states move their Medicaid enrollees into managed care plans, non-English-speaking or limited-English-proficient recipients could face the risk of being "locked into" managed care systems which do not adequately meet their needs for linguistically and culturally appropriate health care.

This report addresses the issue of managed care and its potential impact on Medicaid recipients who are non-English-speaking or limited-English-proficient. To study state Medicaid managed care requirements for linguistically appropriate health care, the Association of Asian Pacific Community Health Organizations (AAPCHO) conducted a survey of 10 states with high numbers of limited-English-speaking households, reviewed documentation describing the states' policies for reducing language barriers and reviewed existing literature on the provision of linguistically appropriate health care to Medicaid recipients. The focus of the AAPCHO survey was linguistic appropriateness, which is an integral component of culturally appropriate health care. The 10 states surveyed by AAPCHO are : California, Hawaii, Illinois, Massachusetts, Minnesota, New Mexico, New York, Oregon, Texas and Washington. This report presents an overview of Medicaid managed care and linguistically appropriate health care, state Medicaid managed care requirements, discussion of the findings from the AAPCHO survey and recommendations to state working towards improving the delivery of linguistically appropriate health care services to Medicaid managed care enrollees.

❖ 1.2 *Methodology*

AAPCHO surveyed 10 states to determine whether there were specific state guidelines, mandates or requirements for managed care plans to promote cultural sensitivity and to reduce the language barriers faced by culturally and ethnically diverse Medicaid enrollees. Of the top 25 states with the greatest numbers of linguistically isolated households, 10 states with high concentrations of immigrant and limited-English-speaking populations were chosen to determine the existence and scope of state regulations and guidelines regarding the provision of linguistically appropriate health care to Medicaid populations in managed care plans.

Specifically, ten state Medicaid Managed Care offices or departments were contacted (see Appendix A for list of state contacts) and an appropriate contact person was sent a 10 question survey. Additionally, relevant information pertaining to Medicaid managed care contracts was requested. The survey focused on state regulations and guidelines about language access and methodologies utilized by states to compensate health plans for the provision of linguistically appropriate health care services. Federal and state agency reports on Medicaid managed care and the current literature on linguistically appropriate health care for Medicaid populations were also reviewed. Each state Medicaid managed care contact and other AAPCHO identified experts in the field were sent a draft copy of the report to review. Many of their recommendations have been included in this report.

Chapter 2 Overview of Medicaid Managed Care and Linguistically Appropriate Health Care

❖ 2.1 *Medicaid Managed Care*

Managed care combines the financing and the delivery of health care services to control health care costs and to improve access to services. Typically, managed care plans pay providers on a capitation (per patient) rather than a fee-for-service basis and use primary care physicians or other providers as gatekeepers to regulate access to care. Managed care is an organized and coordinated health care system with the following goals: 1) improved access to quality care; 2) assurance of appropriate utilization of services; 3) enhancement of patient and provider satisfaction and; 4) achievement of cost-efficiencies in the delivery of health care.[4] Managed care plans are composed of the following: 1) pre-established provider networks; 2) pre-established reimbursement arrangements; 3) administrative and clinical systems for: utilization review, quality assurance case management and; 4) comprehensive or targeted management of health services.

Managed care has gained popularity with government and business because it is seen as a way to control health care costs while providing coverage to more people. Increasingly, many states are moving their Medicaid enrollees into managed care plans in an effort to improve access to health care while containing health care costs. Although there have been prepaid health plans in Medicaid since the 1960s, the Omnibus Budget Reconciliation Act of 1981 (P.L. 97-35, section 2175(b)) gave states greater flexibility to design managed care health plans under section 1915(b) of the Social Security Act.[5] In addition, the Health Care Financing Administration (HCFA) allows states to experiment with innovative approaches to managing Medicaid through research and demonstration projects authorized under section 1115 of the Social Security Act.[6] In most cases, states must obtain what is commonly known as a 1115 waiver from HCFA of federal statutory requirements when developing managed care programs.[7] Since 1985, the number of Medicaid recipients enrolled in managed care plans has increased 200 percent.[8] Forty-four states and the District of Columbia now enroll 25 percent of all Medicaid beneficiaries in managed care.[9]

Managed care in Medicaid is not a single health care delivery plan, but rather a continuum of models that share a common approach.[10] At one end of the continuum are prepaid or capitated models of care that pay organizations a per capita amount each month to provide or arrange for all covered services. At the other end are primary care case management (PCCM) models, which are similar to traditional fee-for-service models except that providers receive a per capita management fee to coordinate a patient's care instead of reimbursement for the services they provide. Common to all managed care models in the Medicaid program is the use of a primary care physician to control (i.e. to act a gatekeeper) and coordinate the delivery of health services in a cost-conscious manner.[11] States are aggressively increasing managed care enrollment, using both fully and partially capitated plans as well as primary care case management approaches.[12]

As more states apply for the HCFA 1115 waiver to begin transitioning their Medicaid populations into managed care, the need for establishing minimum standards for the delivery of quality health care within managed care becomes crucial. According to the Government Accounting Office (GAO), Medicaid managed care plans thus far have had mixed results in

improving access to care, assuring the quality of services, and saving money.[13] Moving Medicaid recipients into managed care plans in many states has raised concerns regarding appropriate access to services, especially for certain underserved populations such as the non-English-speaking and limited-English-proficient, the homeless and people with HIV. The impact of managed care on these populations has yet to be determined. Traditional public health providers such as public hospitals and community health centers have expressed concern about the capacity and willingness of managed care plans to meet the special needs of Medicaid beneficiaries.[14] In particular concerns raised include the need for managed care plans to be sensitive and responsive to the cultural and linguistic variations among Medicaid enrollees and to enroll and serve all Medicaid enrollees, regardless of their special needs.[15]

❖ 2.2 *Linguistically Isolated Populations*

Almost 14 million people living in the United States do not have strong English-language skills.[16] More than 10 percent of the population in each of five states (California, New York, Texas, New Mexico and Hawaii) have limited English skills.[17] Approximately 80 percent of all immigrants speak a language other than English at home compared with about 8 percent of the native-born population.[18] In 1990, over 95 percent of Mexicans, Cubans, or Salvadorans spoke Spanish at home. More than 9 of 10 foreign -born from the Philippines, Korea, Vietnam, or China spoke an Asian language, and 79 percent of those from Italy and 58 percent of those from Germany spoke a language other than English.[19] More than half of those who spoke Spanish or an Asian or Pacific Islander language at home did not speak English "very well". In fact, 43 percent[20] of the Mexican foreign born were "linguistically isolated" (defined as "no one in the household age 14 years or older can speak English " 'well' or 'very well' " [21]) as were 30.3 percent of all Asian and Pacific Islander households.[22] Table 1 shows the number of linguistically isolated households in the 10 states surveyed by AAPCHO.

Table 1: Linguistic Isolation by State: 1990 U.S. Census

State	Number of Linguistically Isolated Households	Percentage of Linguistically Isolated Households
California	816,669	2.7
Hawaii	23,949	2.2
Illinois	140,941	1.2
Massachusetts	86,070	1.4
Minnesota	18,595	0.4
New Mexico	35,171	2.3
New York	429,030	2.4
Oregon	16,274	0.6
Texas	353,884	2.1
Washington	35,043	0.7
TOTAL	1,955,626	

High rates of linguistic isolation in these states indicate the need for linguistically accessible health services, especially in areas with high concentrations of immigrant populations. A 1995 national survey of 120 public and private teaching hospitals conducted by the National Public Health and Hospital Institute (NPHHI) revealed that: more than 11 percent of all patients in responding institutes required interpreter services; and among one-third of the responding institutions, 27 percent of their patients on average required interpreter services.[23]

❖ 2.3 *The Legal Mandate for Linguistically Appropriate Health Care*

"Limited-English-proficient" is the term used by the US Department of Health and Human Services (DHHS) Office for Civil Rights to define the portion of the population that is non-English speaking or limited-English speaking. The DHHS Office for Civil Rights considers inadequate interpretation to be a form of discrimination.[24] This stance has its origin in Title VI of the Civil Rights Act of 1964, which states: "No person in the United States shall, on the ground of race, color, or national origin, be excluded from participation in, be denied the benefits of, or be otherwise subjected to discrimination under any program or activity receiving Federal financial assistance.[25] The application of the federal statute to ensure equal educational access for children with limited-English -proficiency, was upheld by the Supreme Court in 1974.

In Lau vs. Nichols (1974) the High Court established that Title VI included within its scope prohibitions against discrimination on the basis of language.[26] The Supreme Court ruled that the San Francisco Unified School District was in violation of the national origin prohibition of Title VI when it failed to provide language assistance to nearly 2,000 students of Chinese ancestry.[27] A recipient of federal funds that is unable to communicate effectively with a substantial limited-English-proficient (LEP) population in its service area subjects that population to discrimination based on national origin.[28] The Office for Civil Rights also requires DHHS-funded health programs to provide patients with limited English skills access to services equal to those provided to English speakers[29]

Despite the legal mandates for the provision of linguistically appropriate care, linguistic and cultural discrimination have not been eliminated in federally supported health programs, due

largely to inconsistent and inadequate enforcement of the law.[30] Due to staff shortages (a staff of 300 oversees 100,000 organizations, which receive DHHS funds), the Office for Civil Rights' compliance monitoring system is essentially complaint-driven.[31]

❖ 2.4 *Accreditation Standards*

In addition to federal mandates for the provision of linguistically appropriate health care, there are health care industry standards set forth by the Joint Commission on Accreditation of Hospital Organizations (JCAHO). According to 1994 JCAHO standards, hospital organizations are expected to demonstrate compliance with the following two standards pertaining to interpreter services[32]:
1) Standard MA.1.3.10.1., a hospital must demonstrate that it provides a plan for effectively communicating in the language(s) of the predominant population group(s) served by the hospital, and as needed, with persons with impaired hearing or speaking skills.
2) Standard ES.1.5., a hospital must demonstrate that, when required frequently in the emergency care area, there is a means of communicating in the languages of the predominant population groups served by the hospital's emergency department.

Presumably, these standards which apply to hospitals should also apply to managed care plans. However, the existing standards promulgated by JCAHO are not specific in defining what is a "predominant population group" or what constitutes "required frequently in the emergency care area". The lack of specificity in these standards effectively allows hospitals and managed care plans to self-determine when a population is predominant and what constitutes frequent requirement in the emergency care area.

❖ 2.5 *Current Status of Linguistically Appropriate Health Care Services*

A language barrier exists between a provider and a patient who speak different languages when clear communication that is vital to ensuring the delivery of quality health care is impeded. Linguistic accessibility requires providing services in a manner that is appropriate for the population served. For health delivery systems, this means ensuring that a sufficient number of personnel or interpreters can directly communicate with the patient in their primary language at key points of contact.[33] Linguistic accessibility also means that service delivery sites must utilize appropriately translated forms, educational materials, signs and posters.[34] The lack of linguistically accessible health care services within managed care plans can pose a serious barrier to health care for Medicaid recipients who speak little or no English.

Health providers and delivery systems at varying degrees have begun addressing the issue of linguistic barriers to health care. The use of interpreters has been the standard solution to the language barrier between patient and provider. The NPHHI survey revealed that while some hospitals employ interpreters, more institutions identified other hospital staff and volunteers as sources for interpretation services.[35] Most patients and clinicians rely on one of three suboptimal mechanisms for interpretation: 1) their own language skills, 2) the skills of patient family or friends, or 3) ad hoc interpreters (bilingual employees). Institutions surveyed relied on contract services and various combinations of staff and volunteers as well as patient family or friends.[36] Each of these methods of interpretation has its own weaknesses in terms of adverse clinical consequences, ethical dilemmas, and patient confidentiality.[37] The survey findings also

concluded that while hospital administrators agreed on the importance of linguistic competence in providing health care, little consensus exists on how to achieve this objective.[38]

The NPHHI survey results revealed that most hospitals utilize a combination of the following: ad hoc interpreters (such as bilingual staff), contract services with language banks such as the AT&T Language Line and also on volunteer interpreters.[39] As evidenced by the results of the NPHHI survey, the mode of delivery of interpretation services across hospitals in the United States varies and for the most part is not organized on a formal basis.

As states incorporate Medicaid populations into managed care plans, the issue of language interpretation and culturally appropriate health care will become acute for limited-English-speaking and limited-English-proficient Medicaid recipients. There are three ways in which limited-English-proficient recipients of Medicaid may be adversely impacted through managed care[40]: 1) complex enrollment procedures, together with language barriers may prevent patients from enrolling with their preferred providers; 2) there could be insufficient staffing in managed care plans to provide interpreter services to limited-English-proficient populations, and; 3) the emphasis in managed care on cost-containment could lead to a general neglect of the enabling services needed to provide linguistically appropriate health care services to limited-English-proficient populations. These adverse impacts on Medicaid managed care populations' access to linguistically appropriate health care services necessitate an assessment of state guidelines or mandates/regulations for managed care plans to provide linguistically appropriate health care to Medicaid enrollees.

According to a GAO survey of the 50 state Medicaid offices, states asserted that managed care is most successful when beneficiaries understand and are willing to comply with rules for obtaining care. Marketing tactics can be used to educate beneficiaries about health plans, but they have also been used to mislead or coerce beneficiaries to gain their enrollment.[41] Thus, in order to appropriately utilize health care services, and to avoid being misled by health plan marketing efforts, non-English-speaking or limited-English-proficient Medicaid recipients need linguistically appropriate education regarding their benefits and their rights under managed care.

Chapter 3. State Medicaid Managed Care Requirements for Linguistically Appropriate Health Care Services

The Association of Asian Pacific Community Health Organizations has conducted a survey of 10 states to determine the extent of state guidelines or statutes/regulations for managed care plans to provide linguistically appropriate health care to Medicaid enrollees. The AAPCHO survey focused on state-level regulations and mandates for managed care organizations to provide linguistically appropriate services for Medicaid enrollees. This survey updates and provides an in-depth look at the issues covered by the NPHHI survey. The information gathered from the survey, from related documentation and from federal/state agency reports on Medicaid managed care, has been summarized in Table 2. An analysis of state requirements, monitoring and enforcement mechanisms and compensation methods with regards to language access follows in Chapter 4.

❖ 3.1 *State Guidelines and Regulations*

Table 2 summarizes the results of the AAPCHO survey and review of state documentation for the provision of linguistically appropriate health care to Medicaid managed care enrollees. For an in-depth description of state regulations, please refer to Appendix B.

Table 2 : Summary of Reported State Medicaid Managed Care Requirements for Interpretation Services

State / Status of Medicaid Managed care	Medicaid Managed Care Language Requirements[42]
California[43] Over 20 years of managed care experience.	• Contractor will ensure compliance with Title VI of the Civil Rights Act of 1964 (42 U.S.C. Section 2000d, 45 C.F.R. part 80) which prohibits recipients of federal financial assistance from discriminating against persons based on race, color or national origin. This is interpreted to mean that a limited English proficient individual is entitled to equal access and participation in federally funded programs through the provision of bilingual services.[44] • contractor will provide 24 hour access to interpreter services for all members at all provider sites within the Contractor's network either through telephone language services or interpreters. • The Contractor will provide linguistic services to a population group of mandatory Medi-Cal eligibles residing in the proposed service area who indicate their primary language as other than English and who meet a numeric threshold of 3,000 or a population group of mandatory Medi-Cal eligibles residing in the proposed service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes.[45] • Department tracks the ethnicity and primary languages of enrollees through the information provided at the time the beneficiary applies for benefits.
Hawaii[46] Implemented the Hawaii QUEST Program on August 1, 1995.	• All participating managed care organizations are required to provide interpreter services for those who are unable to get their health care due to a language barrier. • State does not currently track the number of linguistically isolated or limited-English-proficient Medicaid enrollees.
Illinois[47] Illinois has had a managed care (HMO) program since 1974. The Department of Public Aid is planning to expand the program in 1995-1996.	• The Illinois Department of Public Aid and HMOs currently provide materials only in English and Spanish. Specific language requirements are not addressed in the contract. • All HMO contractors have multi-lingual provider networks.

Table 2 : Summary of Reported State Medicaid Managed Care Requirements for Interpretation Services - Continued

State / Status of Medicaid Managed care	Description of Medicaid Managed Care Language Requirements
Massachusetts[48] Massachusetts has had a Medicaid HMO program since the early 1970s; overall managed care program has been implemented since January 1, 1992.	• HMOs must demonstrate a capacity to accommodate varying cultural needs of enrollees in major ethnic groups within their service area. • Multi-lingual providers must be available for the most commonly used languages in the HMOs service area. • The Department of Medical Assistance (DMA) collects information on the language spoken by Medicaid recipients. As of July 1995, a new system will be in place to collect language spoken based on the language in which the eligibility form is requested. • Non-English speaking enrollees must have a choice of at least two multi-lingual primary care providers who can provide services to and speak to the enrollee in his or her primary language.[49]
Minnesota[50] Currently, 140,000 enrollees in the Medicaid Managed Care Program.	• Each plan must demonstrate capacity to provide appropriate access before it may renew a contract with the state. • Health plan must offer appropriate services for persons with language barriers, including: interpreter services, bilingual staff, culturally appropriate assessment and treatment. • Upon receipt of the enrollment form, the Health Plan must contact the enrollee by phone or mail in the appropriate language to inform them how to obtain health care services.[51] • Health plans are required to conduct an initial assessment of each patient to determine ability to speak English. Based on the findings, each patient must be contacted in the appropriate language with information on how to receive health care services. [52]
New Mexico[53] Currently operates the Primary Care Network (PCN), a primary care case management program. May begin contracting with managed care plan in October, 1996.	• Within the PCN: No specific requirements for individual providers to provide linguistically appropriate health care. However, providers are asked about their linguistic abilities and those of their staff. • New Mexico does contract with a number of individual providers who speak a variety of languages and Native American dialects.

Table 2 : Summary of Reported State Medicaid Managed Care Requirements for Interpretation Services - Continued

State / Status of Medicaid Managed care	Description of Medicaid Managed Care Language Requirements
New York[54] As of July, 1995, approximately 24% of Medicaid recipients enrolled in managed care. NY is applying for a 1115 waiver to implement a mandatory Medicaid managed care program.	• Health plans must make available written materials (e.g. member handbooks) and interpreter services in languages other than English, whenever 10 percent or more of a plan's membership in any borough/county, subject to a minimum of 500, speak a particular language other than English as a first language. • New York requires plans to have 'bilingual capacity' both during and after business hours, for any language that is the primary language of 10 percent or more of the enrolled population.[55] • In providing local departments of social services with lists of primary care providers in their service areas, health plans must note any languages other than English spoken in the provider's office. • For persons requiring ongoing mental health or substance abuse services, health plans must have the capacity to provide culturally and linguistically appropriate services, including therapy services in languages other than English, to the extent reasonable and practical given provider capacity in the plan's service area. • Methods for promoting HIV prevention information to plan enrollees must be culturally and linguistically appropriate. • Health plans proposing to serve the New York City area must demonstrate the capacity to provide culturally and linguistically appropriate behavioral health care services. They must also have the capacity to provide therapy services in the languages spoken by their member, to the extent reasonable and practical.

Table 2 : Summary of Reported State Medicaid Managed Care Requirements for Interpretation Services - Continued

State / Status of Medicaid Managed care	Description of Medicaid Managed Care Language Requirements
Oregon / Implemented Medicaid Managed Care on February 1, 1994.[56]	• Contractors to ensure access to qualified interpreters for primary language of each substantial population of non-English speaking members. (substantial population - defined as at least 35 non-English speaking people speaking the same language enrolled with Contractor)[57] • Plans must offer written information in the primary language of each substantial population.[58] • All health plans provide translation services to any member (or their representative) who requests such a service. The health plans provide this service free of charge to ***any*** member who requires it. • State informs plans which enrollees speak different languages with language code labels. • State provides health plans with marketing materials in 8 languages. • State conducts outreach to Medicaid enrollees in 8 languages. • State Medicaid Office tracks the number of non-English speaking enrollees.
Texas /[59] Implementation of Medicaid Managed Care began on a pilot basis in 1993; In the process of expanding it to 3 sites next year; In the process of preparing its 1115 waiver to be able to implement Medicaid managed care statewide.	• Health plan to provide interpreter services for members as necessary to ensure availability of effective communication regarding treatment, medical history or health education.[60] • Texas follows HCFA guidelines in providing interpretation services in the primary language of a limited-English-proficient (LEP groups) which exceed 10% of the Medicaid population in the catchment areas served by the HMO (or health plan)[61] • Cultural Competency : The HMO shall develop a written plan which is comprehensive, coordinated, and culturally competent describing how the HMO will address the special health care needs of members.[62] • HMO will provide interpreter services for members as necessary to ensure availability of effective communication regarding treatment, medical history or health education.[63]

Table 2 : Summary of Reported State Medicaid Managed Care Requirements for Interpretation Services - Continued

State / Status of Medicaid Managed care	Description of Medicaid Managed Care Language Requirements
Washington / Medicaid Managed Care began in October, 1993	• Interpreter services to be provided for all members with a primary language other than English for all interactions between the member and the contractor or any of its providers.[64] • All written materials available to members shall be translated as necessary to meet the requirements of RCW 74.04.025 - Bilingual services for non-English speaking applicants and recipients. • Initial client contact materials shall inform clients in all primary languages of the availability of interpretation services for non-English speaking persons. Basic informational pamphlets shall be translated into all primary languages.[65] • "Primary languages" includes but is not limited to Spanish, Vietnamese, Cambodian, Laotian and Chinese.[66] • The department tracks the number of limited-English-proficient Medicaid enrollees[67]

Case Study for a State-Wide Approach to the Provision of Linguistically and Culturally Appropriate Services : State of California

Among the states surveyed, California is at the forefront of developing a state-wide plan for providing culturally and linguistically appropriate health care Medi-Cal managed care enrollees. The state-wide Cultural and Linguistic Requirements Subgroup * [1] convened by the state, developed recommendations to provide culturally and linguistically appropriate services to Medi-Cal managed care enrollees. One of the first endeavors in the country to bring together a broad spectrum of individuals and agencies, from consumer advocates to service providers, to discuss the issues and to operationalize cultural competency for major health programs.

The advisory group first convened in mid-September 1993, met four times in 10 weeks to set standards for culturally and linguistically competent services in the Medi-Cal Managed Care Program. Additionally, the National Health Law Program has analyzed the recommendations for culturally and linguistically appropriate health care.[68] A summary of the recommendations from the Cultural and Linguistic Requirements Subgroup and the National Health Law Program is in Appendix C.

[1] The membership of the group includes consumer advocates and representatives of community clinics, health maintenance organizations, and state and local health departments. This subgroup works collaboratively with the California Cultural Competency Project of the Institute for the Study of Social Change of the University of California at Berkeley.

❖ 3.2 *Modes of Delivery of Interpreter Services*

Surveyed states differed in their requirements for plans to provide interpreter services. Most of the 10 states do not require the use of professional or certified translators or interpreters. One exception is the state of Washington which requires interpreters to be certified, and have signed a core provider agreement with the Department of Social and Health Services before it will reimburse for interpreter services.[69] In addition, the state of Texas requires plans to maintain a list of interpreters who are "on call", many of whom come from the community.[70] The Texas contract for Medicaid managed care plans also states that "family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical." California also has specific requirements prohibiting family members from acting as interpreters.[71] Specific requirements such as these improve the quality and access to interpreter services for Medicaid patients.

❖ 3.3 *State Monitoring and Enforcement Methods*

The 10 states were also surveyed about the manner in which they evaluated health plans to ensure compliance with state requirements and assured non-discriminatory practices based on language. The results of the AAPCHO survey are summarized in Table 3.

Table 3 : Summary of State Monitoring and Enforcement Methods for Interpreter Services

State	Description of Monitoring and Enforcement Methods
California[72]	• Primarily through on-site evaluations, satisfaction surveys and grievance procedures.
Hawaii[73]	• The Hawaii Quest Program has several quality assurance teams which review each plan for compliance and quality care. • The Request for Proposal (RFP) prohibits discrimination of any kind. Both the agency and the Civil Rights Office provide oversight.
Illinois[74]	• Complaint driven only; individual issues or complaints are addressed.
Massachusetts	• Health plans must document their language and cultural appropriateness provisions and have these documents available for inspection at any time.[75] • Health plans must also provide the Massachusetts Division of Medical Assistance (DMA) with copies of their materials in foreign languages and inform the state of any planned programs to improve cultural competence.[76] • In response to the RFP, health plans must submit detailed information on how they meet the contract requirements. Those plans that fail to meet the purchasing specification will be required to have an improvement goal on that particular specification.[77] • DMA tracks the situations in which a Medicaid enrollee changes HMOs. If a member reported that they dis-enrolled based on perceived discrimination, DMA will investigate.[78]

Table 3 : Summary of State Monitoring and Enforcement Methods for Interpreter Services Continued

State	Description of Monitoring and Enforcement Methods
Minnesota	• Plans are required to submit their policies on translation and cultural sensitivity during the application process and by providing ombudsperson services.[79] • Complaint review[80]
New Mexico[81]	• Grievance procedures and availability of toll-free number for complaints. Non-discrimination provision of contracts enforced by agency.
New York[82]	• Currently, social service districts review each plan to determine whether they have appropriate written materials and staff for their service area. • Starting in the Fall of 1995, New York State Department of Health will conduct readiness reviews for all plans contracting to serve Medicaid recipients including the monitoring plans' multilingual capacity. • All social service districts must monitor complaints. • Complaints are addressed by the state.[83]
Oregon	• Plans required to submit their procedures for ensuring cultural appropriateness prior to contracting. • State evaluates these procedures during site visits and as problems arise.[84] • When a health plan creates any educational information, it is reviewed by Office of Medical Assistance Programs (OMAP) and the Health Care Financing Administration (HCFA). All materials must be written at the 6th grade level and be clear and concise. • OMAP's Evaluation and Analysis Unit evaluates all health plans on a yearly basis and works with the plans to meet the standards of the Oregon Health Plan. • Clients have many avenues to file a complaint (through Complaint Procedures) if they are not receiving the services they need.[85] • Client also has direct access to their case worker, the Governor's Advocacy Office or any Advocacy Group if they feel they have hit a barrier in receiving services.[86]
Texas[87]	• State review materials before health plans send them to potential and current enrollees. • Through the complaints and grievances process. • State monitors rates of dis-enrollments and makes inquiries into plans and providers which have multiple dis-enrollments due to communications barriers.
Washington[88]	• State requests copies of materials required to be translated. • State monitors client complaints and complaints filed by advocacy groups.

❖ 3.4 *Sources of Funding and Compensation for Interpreter Services*

The AAPCHO survey and literature search revealed that funding for interpreter services is highly variable among states and institutions. The NPHHI survey asked hospitals to identify the sources of funding that covered the costs associated with interpreter services. Most hospitals used general funds to cover the costs of providing interpreter services and almost none of the funding for interpreter services came from federal, state, or local grants.[89] In contrast, 5 percent or fewer identified third party payers or direct governmental sources for such services.[90] Table 4 summarizes the data from the NPHHI survey:

Table 4 : NPHHI Results: Sources of Funding for Interpreter Services, 1993[91]

Funding Source	Yes % (n of hospitals)	No % (n of hospitals)	Don't Know % (n of hospitals)
Third Party Payers	5.0 (3)	68.3 (41)	26.7 (16)
State or Local Grants	0.0	73.3 (44)	25.0 (15)
Federal Grants	1.7 (1)	71.7 (43)	26.7 (16)
Hospital General Funds	65.2 (43)	24.2 (16)	10.6 (7)
Other	15.2 (5)	48.5 (16)	36.4 (12)

The NPHHI survey revealed 68.7 percent of the hospitals surveyed earmarked funds in their budget for interpreter services, and 38.6 percent of hospitals surveyed monitored interpreter services for billing purposes.[92]

Costs of Interpreter / Translator Services

The costs of interpreter services in hospitals varied, depending upon the type of interpreter services used. In the NPHHI survey, the average cost of an interpreter request was $20.04, although costs for interpreter services varied widely among hospitals.[93] The average annual salary for the full-time interpreters reported in 22 hospitals was $29,618. Annualized salaries ranged from $16,000 to $66,560, with a median of $27,020.[94] Hourly wages in ten hospitals ranged from $10.00 to $32.00 per hour (which is annualized to $66,560).[95]

Results of AAPCHO Survey of 10 States

AAPCHO also surveyed the 10 states regarding compensation for interpreter services. Most of the surveyed states did not provide exact dollar amounts on compensating managed care plans for providing linguistically appropriate health care. Table 5 summarizes the results of the AAPCHO survey.

Table 5 : Methods of Compensation for Interpreters by State

State	Methods of Compensation
California	• Language interpretation is not reimbursed separately in the capitation rate.[96]
Hawaii	• Enabling services which includes language interpretation are added on to the capitation rate.[97] * [2] • Each plan required to display the cost of these services separately in order for the state to be assured that they had the capability to provide the services and the cost was considered in the development of the capitation rate.[98]
Illinois	• There is no language component in the current rate structure.[99]
Massachusetts	• Language interpretation is included in the managed care capitation rate for the HMOs.
Minnesota	• Cost of languages services are calculated into the capitated rate paid to all health plans. Average cost of interpreter assumed to be $75 per encounter; average of five visits per year per member; Cost per member per year is $375[100]
New Mexico	• None[101]
New York	• There is no separate reimbursement for linguistically appropriate care. All plans are required to meet state language requirements for staffing and written materials.[102]
Oregon	• Reimbursement for interpretation services is part of the 6 percent administrative fee that the health plans receive in their capitation rate.[103]
Texas	• Language interpretation is not reimbursed separately, it is included within the capitated rate.[104]
Washington	• The Department shall pay for interpreter services for medical encounters and Dept. Fair hearings but only for interpreters who are certified by and have signed core provider agreement with the Dept.

[2] The current pay rate varies among plans; upto $ 3 per member per month for enabling services.

Case Study for Reimbursement for Interpreter Services : State of Minnesota

Among the surveyed states, Minnesota had the most progressive reimbursement approach for interpreter services. The following is a case-study of Minnesota's reimbursement method.

Interpreter Services Calculated into the Capitated Rate

The state of Minnesota has assured that Medicaid beneficiaries have access to language-appropriate health care services in managed care plans. The state requires managed care organizations under state Medicaid contracts to make interpreting and translation services available when needed. Because health plans are required to provide interpreter services, the costs of providing such services are calculated into the capitated rate paid to all plans.

"The projected per member per month value of interpreter services was calculated using the following methodology (for 1995 and 1996). The average cost of an interpreter service was assumed to be $75 per medical encounter in FY 92 and trended forward[105 106]. With an average of five visits per year per member, the cost per member is $375 per year. Approximately 2.3% of enrollees are non-English speaking. This proportion was applied to the current enrollment figure to arrive at the per member per month cost of interpreter services."[107]

As states move their Medicaid populations into managed care, the manner in which health plans are reimbursed for providing linguistically appropriate services is a central issue in ensuring that Medicaid enrollees have appropriate access to linguistically appropriate care. The results of the NPHHI survey and the AAPCHO survey demonstrated the broad variability in reimbursement for and costs of interpreter services.

Regulations, monitoring requirements and compensation methods for linguistically appropriate health care varied among the states surveyed by AAPCHO. Table 6 provides a comparison between the states on regulations, monitoring requirements and compensation, followed by an analysis of state regulations, monitoring requirements and reimbursement methods.

Table 6 : Comparison of AAPCHO Surveyed States' Regulations, Monitoring Requirements and Compensation

State	Regulations	Monitoring Requirements	Compensation
California	Specifies a numeric threshold of 3,000 or 1,000 in a single zip code or 1,500 in two contiguous zip codes for contractor to provide linguistic services to a population group of mandatory Medi-Cal eligibles who indicate their primary language as other than English.	On-site evaluations Satisfaction surveys Grievance procedures	Language interpretation is not reimbursed separately.
Hawaii	No threshold specific number or percentage. Managed Care organizations are required to provide linguistically appropriate care to plan members.	Health plans reviewed by state for compliance and quality of care.	Enabling services which includes language interpretation are added on to the capitation rate.
Illinois	No specific language requirements in the contract. However, all HMO Contractors have multi-lingual provider networks.	Individual issues or complaints are addressed by state.	There is no language component in the current rate structure.
Massachusetts	Requires interpreter services to be provided to all members.	Health plans to avail all documents re: their language and cultural appropriateness for inspection at any time. Tracks dis-enrollees and investigates reports of discrimination.	Language interpretation is included in the managed care capitation rate for the HMOs.

Table 6 : Comparison of AAPCHO Surveyed States' Regulations, Monitoring Requirements and Compensation - Continued

State	Regulations	Monitoring Requirements	Compensation
Minnesota	Requires interpreter services to be provided to all members.	Plans are required to submit policies on translation and cultural sensitivity during the application process; provide ombudsperson services. Complaints are addressed by State.	Costs of language services are calculated into the capitated rate paid to all health plans. Average cost of interpreter assumed to be $75 per encounter.
New Mexico	Within the Primary Care Network (PCN): No specific requirements for individual providers to provide linguistically appropriate health care.	Grievance procedures and availability of toll-free number. Non-discrimination provision of contracts enforced by agency	No separate compensation.
New York	For more than 5 percent non-English speaking enrollees, plans required to make bilingual marketing materials. For more than 10 percent non-English-speaking, plans required to have bilingual capacity both during and after business hours.	Review of written materials and staff to determine appropriateness for their service area. Readiness reviews of health plans conducted in Fall, 1995 including their multilingual capacity. Monitoring of complaints.	No separate reimbursement for linguistically appropriate care.
Oregon	Specifies a threshold number (35 members) before health plans have to provide linguistically appropriate materials; Requires interpretation services to be provided for any individual requiring linguistically appropriate health care.	Review of procedures for ensuring cultural appropriateness prior to contracting. Review of educational materials. Evaluation of health plans on a yearly basis. Complaints procedures.	Reimbursement for interpretation services is included in the 6 percent administrative fee that the health plans receive in their capitation rate.

Table 6 : Comparison of AAPCHO Surveyed States' Regulations, Monitoring Requirements and Compensation - Continued

State	Regulations	Monitoring Requirements	Compensation
Texas	Specifies a threshold percentage (10 percent) before health plans have to provide linguistically appropriate care	Review of materials before health plans send them to potential / current enrollees. Complaints / grievances procedures. Monitoring of dis-enrollment and inquiry into plans with multiple dis-enrollments due to communication barriers.	Reimbursement for language interpretation is included within the capitated rate.
Washington	Requires interpreter services to be provided to all members.	State requests materials required to be translated. Monitor client complaints and complaints filed by advocacy groups.	The department shall pay for interpreter services for medical encounters and Department Fair hearings but only for interpreters who are certified by and have signed core provider agreement with the Department

❖ 4.1 *Discussion of State Requirements for Linguistically Appropriate Health Care Services*

Results from the AAPCHO survey, literature and review of other Medicaid managed care reveal that states address the provision of linguistically appropriate care to Medicaid managed care populations in varied ways. The majority of the 10 states surveyed however have addressed this issue to some extent.

In some states, the right to interpreter services is only extended to patients that make up a specified percentage or threshold number of the plan's enrollees. The state of California has the lowest threshold percentage requirement of 5 percent of Medi-Cal total enrollees before health plans have to provide translation services.[108] The state of Oregon also has a relatively low numerical threshold requirement (35 non-English speaking members speaking the same language enrolled with the contractor) before the contractor must provide linguistically appropriate health care.

States which specify threshold percentages or absolute numbers at which point plans must provide linguistically appropriate health care, while being specific are in effect limiting access to care for those non-English-speaking and limited-English-proficient populations who fall below the set threshold. Furthermore, some states which specify a threshold for the provision of linguistically appropriate services are unclear in identifying which entity (the state, the health

plan or the population) is responsible for determining whether a certain population meets the threshold requirements. This lack of clarification of responsibility may ultimately lead to inefficiency and failure to provide linguistically appropriate care for populations which meet the threshold requirements.

States with vague guidelines or requirements give health plans broad jurisdiction on how to provide linguistically appropriate services for their enrollees. States without any guidelines or regulations for the provision of linguistically appropriate care to Medicaid populations are neglecting to address an issue which can potentially exacerbate the barriers to care faced by some Medicaid populations.

Although guidelines for linguistically appropriate care have been promoted in many states, few require managed care plans to provide interpreter services to all enrollees. Only a few of the states surveyed, such as Washington and Minnesota, require plans to provide linguistically appropriate care to all individuals. The states of Texas and California also specify that family members should not be used as interpreters.

Title VI of the Civil Rights implies that every individual is entitled to linguistically appropriate care, not only groups of individuals who are within a certain threshold. Since health plans are receiving Federal funds when they are contracting with states to serve Medicaid recipients, health plans are prohibited under Title VI of the Civil Rights Act to discriminate on the basis of language. California specifically states in its Request for Application a contractor will ensure compliance with Title VI of the Civil Rights Act and further states "This is interpreted to mean that a limited-English-proficient individual is entitled to equal access and participation in federally funded programs through the provision of bilingual services."[109] Such specificity within the RFA underscores the importance of providing linguistically appropriate health care to all enrollees.

As indicated by Table 6, state variations in providing linguistically appropriate health care highlight the need for developing national guidelines to address linguistically appropriate care for Medicaid population. While it may be financially challenging for health plans to accommodate the language needs of all enrollees, Medicaid beneficiaries in managed care plans who fall below the threshold run the risk of being locked into plans which do not meet their language needs. Furthermore, providing linguistically appropriate services will likely reduce financial costs in the long run in terms of reduced utilization of intensive or emergency care.

❖ 4.2 *Discussion of State Monitoring Methods*

Many states are increasing their efforts to build responsible and effective quality assurance systems as they move their Medicaid populations into managed care plans.[110] The 10 states surveyed by AAPCHO utilize a variety of methods to monitor and enforce language requirements (see Table 6).

Monitoring and enforcement of requirements for linguistically appropriate care also varied among the states. Some states such as Oregon and Massachusetts have multiple modes of monitoring whether health plans were meeting state standards. A few states (Illinois, Minnesota and Washington) rely primarily on general grievance and complaints procedures to identify barriers in the communication process between enrollees and providers. Primary reliance on the

grievance/complaints procedures can preclude those with limited-English-speaking abilities from lodging complaints if the process and the associated paperwork are not linguistically appropriate.

New York and Massachusetts conduct periodic review of health plans and examine the provision of linguistically appropriate health care services. Oregon annually evaluates all health plans to ensure that they are meeting the standards of the Oregon Health Plan. Such periodic or annual reviews of health plans are a necessary part of ensuring compliance with state standards.

A few states (Massachusetts, Oregon, Texas and Washington) require plans to submit bilingual materials to the State for review. Review of translated materials by the state is also an integral part of assuring linguistically appropriate health care services to Medicaid managed care enrollees. Washington and Minnesota which required health plans to initially contact limited-English-speaking and non-English-speaking enrollees in their primary languages have shown innovation in providing linguistically appropriate care to an enrollee from the outset.

Some states also monitor the dis-enrollment rates and conduct follow-up to determine the reasons for dis-enrollment. Once again, this mode of monitoring is a necessary component of ensuring that health plans are meeting state requirements. However, follow-up with non-English-speaking or limited-English-proficient persons who have dis-enrolled must also be linguistically appropriate to effectively determine the reasons for dis-enrollment.

The variation among states also indicates the necessity of formulating standards and guidelines for managed care plans to provide a systematic method of monitoring and enforcing requirements for linguistically appropriate care. The AAPCHO survey identified several necessary components of monitoring linguistic appropriateness of health care services. AAPCHO recommends that at a minimum, compliance be monitored with periodic reviews of plans and translated materials, grievance procedures, and follow-up to determine reasons for dis-enrollment.

❖ 4.3 *Discussion of State Compensation Methods*

Appropriate compensation for interpreter services is a necessary precursor to the provision of linguistically appropriate health care to Medicaid enrollees in managed care plans. States which assume that the cost of providing interpreter services are part of existing administrative costs are not appropriately acknowledging the monetary costs of providing linguistically appropriate health care for Medicaid managed care enrollees.

The inclusion of interpreter compensation into the capitated rate (Minnesota and Massachusetts) and the provision of separate reimbursement for language services by the states of (Hawaii and Washington) provides health plans and providers with the appropriate financial support to be able to meet state requirements in providing linguistically appropriate health care to Medicaid enrollees. Without the explicit calculation of all the costs of providing linguistically appropriate health care into capitated rates or by providing separate funds to managed care plans and providers who provide linguistically appropriate health care to enrollees, it will be difficult to implement existing and future state regulations regarding linguistically appropriate health care. Managed care plans also need to appropriately reimburse health care providers who provide linguistically appropriate health care.

Chapter 5 Recommendations for Linguistically Appropriate Health Care

State Medicaid managed care agencies and contracted health plans face a challenge in providing linguistically appropriate health care to a linguistically diverse Medicaid populations. Many states and health care delivery institutions have begun to address the challenge of providing linguistically appropriate health care for patients. However, the extent of state regulations and health plan provisions for language-appropriate services varies. In this section, we present a set of conclusions and recommendations based on results from the AAPCHO survey and also from our review of the existing literature on linguistically appropriate health care. While this analysis focused on the Medicaid population, the recommendations can be applied to all those who are in need of linguistically appropriate health care.

Currently, there are limited models for the delivery of linguistically appropriate health care. As noted earlier, states and health delivery organizations have adopted a variety of regulations and models for the provision of linguistically appropriate health care. AAPCHO makes the following recommendations for the provision of linguistically appropriate health care at the regulatory and at the organizational levels.

❖ 5.1 *Legislative and Regulatory Recommendations*

Regulatory or legislative requirements must be made for managed care plans to provide linguistically appropriate health care. While many managed care plans have begun to address the issue, for others, the imposition of requirements or guidelines from a regulatory perspective will serve as the necessary impetus to the provision of language-appropriate services. However, regulations developed should be specific to ensure that managed care plans provide language-appropriate services to each member in need, not only to those who fall within a certain threshold.

In the process of conducting the survey of the 10 states, AAPCHO determined that there must be more communication between state Medicaid managed care agencies to compare models for providing of linguistically appropriate health care services. Many of the states surveyed by AAPCHO were not aware of how other states are approaching the issue of linguistically appropriate health care for Medicaid managed care populations. However, most states surveyed expressed a desire to learn about the regulations and guidelines of other states, and needed a mechanisms to do so. The establishment of a Medicaid managed care clearinghouse at the national level would facilitate the exchange of information between states and could result in standardized requirements for linguistically appropriate health care across the states.

Most of the states surveyed have not established standards for health plans to provide linguistically appropriate health care. The lack of established standards for linguistically appropriate care at the state and at the federal level renders the evaluation of health plans difficult or impossible. Appropriate quality assurance standards for interpreter services need to be developed. The provision of quality services and cost should be measured against these standards. Table 7 summarizes key concerns in providing linguistically appropriate health care to Medicaid enrollees, and offers recommendations to improve the delivery of health services to non-English-speaking and limited-English-speaking Medicaid enrollees. These recommendations can be adapted to improve the delivery of health services to all non-English-speaking and limited-English-speaking individuals.

Table 7 : Legislative Recommendations for Linguistically Appropriate Health Care

Issue	Recommendation
• **Standards & Guidelines** - Currently there are no universal standards for the provision of linguistically appropriate health care.	• States are recommended to work with managed care plans, and with experts in ethnic communities (i.e. community health centers/clinics) to establish standards and models of delivery for the provision of linguistically appropriate health care. • Standards need to be established for: linguistic and cultural competence, training of interpreters/health professional staff, staffing ratios and evaluation.
• **Legal Mandate** - Currently federal (Title VU) and state regulations regarding the provision of linguistically appropriate health care are weakly enforced.	• Federal and state agencies must rigidly enforce the Title VI of the Civil Rights Act of 1964, by increasing the funding and staffing levels for enforcement.
• **Needs Assessment & Planning** - Currently many states and health plans do not track the number of linguistically isolated Medicaid enrollees	• States need to track the total number of linguistically isolated Medicaid enrollees as well as the number of linguistically isolated enrollees, in each managed care plan; • States need to provide health plans with a continually updated list of linguistically isolated enrollees within each plan. • States should specify in the contract with managed care plans the methodology to be used to determine the language needs of enrollees. • Thresholds should be set for level of onsite coverage with provision to address those populations which fall below the threshold.
• **Access** - It is highly probable that many Medicaid enrollees will lack access to linguistically appropriate health care within managed care plans because of thresholds, lack of interpreter services, and lack of established standards.	• Improve access to linguistically appropriate health care for ***all*** Medicaid enrollees by requiring managed care plans to provide interpreter services at key points of contact, using trained in-house interpreters, contracting with community health centers/clinics with proven experience and track record of providing linguistically appropriate health care or via language banks with documented health/medical setting and vocabulary training. • States should recommend the formation of linkages between health care providers to promote collaborative efforts.[111] • States should recommend managed care contractors to set long-term recruitment goals for all levels of health professionals to address the language needs of enrollees.

Table 7 : Legislative Recommendations for Linguistically Appropriate Health Care Continued

Issue	Recommendation
• **Marketing Guidelines** - While many states do have guidelines about marketing in general, there is a lack of guidelines for marketing to non-English-speaking and limited-English-speaking Medicaid enrollees.	• The Office of Managed Care in each state needs to establish guidelines for health plans to appropriately market to non-English-speaking and limited-English-speaking Medicaid enrollees.
• **Interpreter Training** - Currently, few states mandate professional training for interpreters, and appropriate, confidential interpretation is not available to all who need it.	• Professional training of interpreters, a training curriculum for (volunteer interpreters) and an accreditation process need to be developed at the national level. • States should recommend managed care plans to utilize formally trained interpreters or volunteers. • States should recommend managed care plans to limit and eventually eliminate the use of family members as interpreters except in absolute emergencies. • Recommend managed care plans to train health care professionals on how to work with interpreters and how to appropriately serve multicultural populations.
• **Communication** - Currently many states are not informed about how other states are providing linguistically appropriate health care for Medicaid enrollees.	• Develop a Medicaid Managed Care Clearinghouse at the national level (e.g. through consumer groups or through HCFA) to facilitate the exchange of information between states.
• **Monitoring and Evaluation** - Currently, monitoring and evaluation of managed care plans vary among states.	• State Medicaid Managed Care Offices have to adopt and enforce strict monitoring methods for managed care plans including: 1. State Medicaid managed care programs need to develop standard management / quality assurance tools; 2. State Medicaid managed care programs should evaluate written materials (marketing and educational materials) for linguistic and cultural appropriateness; 3. State Medicaid managed care programs should conduct regular site visits to ensure managed care plans are meeting state requirements before re-negotiating contracts; 4. Managed care plans should be required to conduct linguistically appropriate patient satisfaction surveys and report the result to State Medicaid managed care Offices; 5. State Medicaid managed care programs should conduct linguistically appropriate Medicaid enrollee satisfaction surveys, track the reasons for dis-enrollment and use the results in re-certifying managed care plans.

❖ 5.2 *Recommendations for Appropriate Compensation of Linguistically Appropriate Health Care Services*

Most states did not separately finance the provision of language-appropriate health care services to Medicaid enrollees. The reimbursement strategy used by the state of Minnesota should be considered by other states which currently lack specific reimbursement rates or strategies for the provision of interpreter services. States which mandate the provision of linguistically appropriate health care without providing adequate financing are in effect limiting the capability of managed care plans to abide by state regulations. As shown by the AAPCHO survey, many of the states did not separately allocate funds for health plans which were providing linguistically appropriate health care; but rather assumed the costs to be included within the set capitated rate. Currently, many providers depend predominantly on internal resources to cover the costs of interpreter services, while third party payers reimburse only a fraction of overall costs.

States in the process of creating or updating their guidelines or regulations regarding linguistically appropriate health care need to focus on the following issues highlighted in Table 8.

Table 8 : Recommendations for Compensation of Linguistically Appropriate Services

Issue	Recommendation
• **Costs** - Currently, little is known about the actual costs of providing interpreter and translation services.	• States should work with health plans to appropriately measure the cost of providing linguistically appropriate health care; • States should utilize the knowledge and experience of community health centers/clinics which have been the traditional providers of cost-effective linguistically appropriate health care.
• **Reimbursement** - Currently, there is insufficient data on how to appropriately cover the costs of providing linguistically appropriate health care.	• States and managed care plans should work together to appropriately reimburse the cost of providing linguistically appropriate health care to non-English-speaking or limited-English-speaking Medicaid enrollees in managed care. • Managed care plans should appropriately reimburse providers who provide linguistically appropriate health care services to health plan enrollees.

❖ 5.3 *Conclusion*

The transfer of Medicaid enrollees into managed care plans promises to challenge all those concerned with providing enrollees with linguistically appropriate care, including state officials, managed care organizations, health care providers, and consumer advocates. Findings from this report reveal innovations in providing linguistically appropriate health care to Medicaid enrollees at the state level. However, these findings also indicate the lack of uniform standards among states in providing and compensating for linguistically appropriate health care to all Medicaid enrollees in managed care organizations.

Access to linguistically appropriate health care professionals as Medicaid enrollees are transferred into managed care, must be a central concern to policy-makers, managed care plans and health care. Prior to enrollment in managed care organizations, many enrollees are likely to have the choice of accessing linguistically appropriate health care from community health centers/clinics and other community-based primary care providers. To ensure that health plans adequately service the language needs of enrollees, it is essential that all states take initiative in developing regulations, monitoring methods and compensation methods for the provision of linguistically appropriate health care. Through the exchange of information, states can share with one another innovative and cost-effective models of delivery of linguistically appropriate health care services to Medicaid managed care enrollees.

APPENDIX A : State Contacts for the AAPCHO Managed Care Survey

State	Contact
California	State of California, Department of Health Services Medi-Cal Managed Care Division Larry Lucero, Administrative Assistant 714 P Street, Room 650 Sacramento, CA 95814
Hawaii	State of Hawaii Department of Human Resources Med-QUEST Division Administration Winifred N. Odo, Administrator 820 Mililani Street, Room 606 Honolulu, Hawaii 96813
Illinois	Illinois Department of Public Aid Office of Communications Dean Schott, Chief Jesse B. Harris Building 100 South Grand Avenue East Springfield, Illinois 62762-0001
Massachusetts	Division of Medical Assistance, Benefit Plans Meryl Friedman, Director HMO Program 600 Washington Street, 5th Floor Boston, MA 02111-1712
Minnesota	Managed Health Care Bill Novak, Consultant Minnesota Dept. of Human Services 444 Lafayette Rd. St. Paul Minnesota, 55155-3854
New Mexico	New Mexico Human Services Department Medical Assistance Division Office of Managed Care CaraLyn Banks, Manager P.O. Box 2348 Santa Fe, New Mexico, 87504-2348
New York	State of New York Dept. of Health Ms. Barbara Frankel, Corning Tower The Gov. Nelson A. Rockefeller Empire State Plaza Albany, NY 12237
Oregon	Oregon Department of Human Resources Office of Medical Assistance Programs Brenda Goldstein, Coordinator 500 Summer Street NE Salem, OR 97310-1014

Texas	Texas Department of Health Bureau of Managed Care Christine Fargo, Policy Analyst 1100 West 49th Austin, Texas 78756-3168
Washington	Department of Social and Health Services Medical Assistance Administration Office of Managed Care D. Andrea Davis, Program Manager P.O. Box 45506 Olympia, WA 98504-5506

APPENDIX B : State Requirements for Linguistically Appropriate Health Care *[3]

State / Status of Medicaid Managed care	Description of Medicaid Managed Care Language Requirements
California[112]	• The Contractor will ensure compliance with Title VI of the Civil Rights Act of 1964. • The Contractor will provide 24 hour access to interpreter services for all members at all provider sites within the Contractor's network either through telephone language services or interpreters. • The Contractor will provide linguistic services to a population group of mandatory Medi-Cal eligibles residing in the proposed service area who indicate their primary language as other than English and who meet a numeric threshold of 3,000 or a population group of mandatory Medi-Cal eligibles residing in the proposed service area who indicate their primary language as other than English and who meet the concentration standards of 1,000 in a single zip code or 1,500 in two contiguous zip codes.[113] • Contractor will assess, identify and report the linguistic capability of interpreters or bilingual employed and contracted staff. • Contractor will ensure that a group needs assessment is conducted to identify the linguistic and cultural needs of the groups who speak a primary language other than English. • Applicant will submit a descriptive analysis and a map which displays the population groups by zip code that meet the 3,000 threshold and the 1,500 and 1,000 concentration standards in the proposed service area based on: a) size of the Medi-Cal eligible population in the proposed service area; b) age and gender breakdown of Medi-Cal eligibles; c) geographic display of the ethnic composition of the Medi-Cal eligibles, by zip code, reported by number (please see endnotes for ethnicities to be reported)[114] and ; d) Geographic breakdown of the number of Medi-Cal eligibles who speak a primary language other than English, by zip code, reported by number (please see endnotes for languages to be reported)[115]

[3] Please Note: This chart contains only the most important aspects of state requirements with regard to linguistically appropriate services. Some states do have additional requirements which do not appear here.

State / Status of Medicaid Managed care	Description of Medicaid Managed Care Language Requirements
Hawaii	• Initially required all the participating plans to provide linguistically and culturally appropriate health care services. Subsequently amended the RFP to make such services optional for the plans. The State's position was to provide the culturally sensitive services to all clients through separate contracts with private agencies to ensure the availability of such services.[116] • All proposals included the provision for such services.[117] • Contract language re: cultural/linguistic services. The health plan shall identify the health practices and behaviors of the recipients to design programs, interventions and services which effectively address cultural and language barriers to the delivery of appropriate and necessary health services.[118]
Illinois / Illinois has had a managed care (HMO) program since 1974. The Illinois Dept. of Public Aid is planning to expand the program in 1995-1996.[119]	• The Illinois Dept. of Public Aid and HMOs currently provide materials only in English and Spanish. Specific language requirements are not addressed in the (contract)[120] • All HMO contractors have multi-lingual provider networks.[121]

State / Status of Medicaid Managed care	Description of Medicaid Managed Care Language Requirements
Massachusetts / Has had a Medicaid HMO program since early 1970s; overall managed care program since January 1 1992.[122]	• HMOs must demonstrate a capacity to accommodate varying cultural needs of enrollees in major ethnic groups within their service area. • Multi-lingual providers must be available for the most commonly used languages in the HMOs service area. • Non-English speaking enrollees must have a choice of at least two multi-lingual primary care providers who can provide services to and speak to the enrollee in his or her primary language.[123] • ***"1.2 Access for Non-English Speaking Enrollees:*** The HMO will ensure multi-lingual providers are available for the most commonly used languages in a particular geographic area. In such areas, the HMO shall ensure that non-English speaking enrollees shall have a choice of at least two (2) multi-lingual primary care providers (PCPs) who can provide services to, and speak to the enrollee in his/her primary language. ***Measure:*** Provide an analysis of where enrollees who require multi-lingual services reside within the HMOs Service Area and provide a list of all multi-lingual PCPs , by Zip Code, in the Service Area identified. Include the percentage of Zip Codes for which the HMO has a large concentration of multi-lingual Enrollees but cannot meet ***Purchasing Specifications 1.1 and 1.2"***[124] • ***"1.12 Member Service Medicaid and MassHealth Managed Care Services Training:*** Member Service representatives who are assigned to respond to either Plan-wide or Medicaid-specific inquiries regarding the HMO shall be capable of answering Enrollee inquiries. Such individuals shall be knowledgeable regarding the Contract between the Division and the Contractor and shall be capable of speaking directly with, or arranging for someone else to speak with, Enrollees in their primary language or through an alternative language device. ***Measure:*** Describe the process and content of initial and ongoing training for Member Service representatives regarding the Division's Contract with the HMO. Include current curriculum, relevant training materials and handouts."[125] • ***"1.15 Cultural Competence :*** The HMO shall demonstrate a capacity to accommodate varying cultural needs of Enrollees in major ethnic groups within the HMO's Service Area. The HMO shall develop an approach to ensure that Enrollees are provided HMO Covered Services in a manner which is culturally sensitive. ***Measure:*** Provide documentation of how the HMO ensures that all aspects of services delivery are culturally sensitive. Such documentation may include, but not be limited to, multi-cultural training curriculum for staff and orientation and education materials for enrollees which are used during the current and prior Contract Year. Also, provide any orientation materials that are available in multiple languages. The HMO shall include plans to improve cultural competence in its response to the Division."[126] • Info is collected on the language spoken by Medicaid recipients. Starting July 1995, a new system will be in place to collect language spoken based on the language in which the eligibility form is requested.

State / Status of Medicaid Managed care	Description of Medicaid Managed Care Language Requirements[127]
Minnesota	• Health plan must agree to submit to the State within 30 days of the effective date of the Contract the following[128]: 1. The process by which the Health Plan will assure availability of interpreter services. 2. The names of agencies or services with which the Health Plan has contracts or agreements for interpreter services. 3. An explanation of how information about such services will be made available to providers with whom the Health Plan contracts. 4. Any changes to the Health Plan's process described above or to provider contracts or agreements for interpret services must be reported on a quarterly basis to the State. • The health plan must offer appropriate services for the following special needs groups when required or requested. MA services must be available within the health plan or through contractual arrangements with providers.[129] 1) "Persons with language barriers: interpreter services, bilingual staff, culturally appropriate assessment and treatment. When an individual is enrolled in a Prepaid Medical Assistance Program (PMAP) the enrollment form will indicate whether the individual needs the services of an interpreter and what languages s/he speaks. Upon receipt of the enrollment form, the health plan shall contact the individual by phone or mail in the appropriate language to inform the enrollee how to obtain primary care services. In addition, whenever an individual requests an interpreter in order to obtain health care services, the health plan must provide the individual with access to an interpreter if such services are reasonably available upon the diligent effort by the HEALTH PLAN to obtain such services." 2) "Cultural and racial minorities: culturally appropriate services rendered by providers with special expertise in the delivery of health care services to the various cultural and racial minority groups." • Each plan must demonstrate capacity to provide appropriate access before it may renew a contract with the state. • Health plan must offer appropriate services for persons with language barriers, including: interpreter services, bilingual staff, culturally appropriate assessment and treatment.[130] • Upon receipt of the enrollment form, the Health Plan must contact the enrollee by phone or mail in the appropriate language to inform them how to obtain health care services.[131] • Health plans are required to conduct an initial assessment of each patient to determine ability to speak English. Based on the findings, each patient must be contacted in the appropriate language with information how to receive health care services.[132] • State's eight health plans have flexibility in determining how to provide language access.

State / Status of Medicaid Managed care	Description of Medicaid Managed Care Language Requirements[133]
New Mexico / Currently operates the Primary Care Network (PCN), a primary care case management. program. May begin contracting with managed care plan in October, 1996.	• Within the PCN: No specific requirements for individual providers to provide linguistically appropriate health care. However, providers are asked about their linguistic abilities and those of their staff. • New Mexico does contract with a number of individual provider who speak a variety of languages and Native American dialects.
New York[134]	• Health plans must note any languages other than English spoken in the provider's office in providing local departments of social services with lists of primary care providers in their service areas. • For persons requiring onging mental health or substance abuse services, health plans must have the capacity to provide culturally and linguistically appropriate services, to the extent reasonable and practical given provider capacity in the plan's service area. • Methods for promoting HIV prevention and information to plan enrollees must be culturally and linguistically appropriate. • Health plans must make available written materials (e.g. member handbooks) and interpreter services in languages other than English, whenever ten percent or more of a plan's membership in any borough/county, subject to a minimum of 500 speak a particular language other than English as a first language. • Health plans proposing to serve the New York City area must demonstrate the capacity to provide culturally and linguistically appropriate behavioral health care services. They must also have the capacity to provide therapy services in the language spoken by their members, to the extent reasonable and practical. • In New York City, plans must provide language translation and assistance for hearing and vision-impaired members when processing complaints. • Implementation of the new managed care plan does not preclude future adjustments to cultural and linguistic requirements for participating health plans.

State / Status of Medicaid Managed care	Description of Medicaid Managed Care Language Requirements[135]
Oregon / Implemented Medicaid Managed Care February 1, 1994.	• Contractors to ensure access to qualified interpreters for primary language of each "substantial" population of non-English speaking members and shall also have appropriate written information. Such interpreters must be capable of communicating in English and the primary language of the Office of Medical Assistance Programs' (OMAP) members and be able to translate medical or dental information effectively.[136] • Plans must offer written information in the primary language of each "substantial population" (defined as at least 35 non-English speaking households speaking the same language enrolled with Contractor.) A non-English speaking household is a household that does not have an adult OMAP member who is capable of communicating in English.[137] • All health plans provide translation services to any member (or their representative) who requests such a service. Translation services are provided by all plans and range from the use of the AT&T Language Line to 24 hour on-call interpreter services. The health plans provide this service free of charge to any member who requires it.[138] • Contractors shall have appropriate written information in the primary language of each substantial population of non-English speaking OMAP Members enrolled with Contractor. • State Medicaid Office tracks the number of non-English speaking enrollees; this information is given to the health plans every month on their enrollee lists and on the set of labels for new enrollees. This information enhances their ability to quickly send the appropriate literature to the non-English speaking member.[139]
Texas / Implementation of Medicaid Managed Care began on a pilot basis in 1993; in the process of expanding it; 3 expansion sites to be implemented next year; Is in the process of preparing its 1115 waiver to be able to implement Medicaid managed care statewide.	• Health plan to provide interpreter services for members as necessary to ensure availability of effective communication regarding treatment, medical history or health education.[140] • Texas follows HCFA guidelines in providing interpretation services in the primary language of a limited-English-proficient (LEP) which exceeds 10% of the Medicaid population in the catchment areas served by HMO (or health plan)[141] • Cultural Competency The HMO shall develop a written plan which is comprehensive, coordinated, and culturally competent describing how the HMO will address the special health care needs of Members. Cultural competency refers to the ability of individuals and systems to provide services effectively to people of all cultures, races, ethnic backgrounds, and religions in a manner that recognizes, values, affirms, and respects the worth of the individuals and protects and preserves the dignity of each. The HMO will employ multi-cultural and multi-lingual staff. The HMO will display to the Texas Department of Health (TDH) a method for incorporating the cultural competency plan into policy-making, administration and practice. HMO shall submit the plan to TDH prior to execution of this agreement and annually thereafter for review and approval.[142] •

State / Status of Medicaid Managed care	Description of Medicaid Managed Care Language Requirements[143]
Texas continued	• Provision of Interpreters Provide interpreter services for Members as necessary to ensure availability of effective communication regarding treatment, medical history or health education. Trained professional interpreters shall be used when needed where technical, medical, or treatment information is to be discussed, or where use of a family member or friend as interpreter is inappropriate. Family members, especially children, should not be used as interpreters in assessments, therapy and other situations where impartiality is critical. The HMO will maintain a current list of interpreters who maintain "on-call" status to provide interpreter services. At a minimum, this list will include individuals that can translate Spanish and American Sign Language.[144]
Washington / Medicaid Managed Care began in October, 1993	• Interpreter services to be provided for all members with a primary language other than English for all interactions between the Member and the Contractor or any of its providers including, but not limited to, all appointments with any provider for any covered service, emergency services, and all steps necessary to pursue the grievance procedure required hereunder. [145] The department tracks the number of limited-English-proficient Medicaid enrollees[146] • All written materials available to Members shall be translated as necessary to meet the requirements of RCW 74.04.025 - Bilingual services for non-English speaking applicants and recipients --Bilingual personnel, when --primary language pamphlets and written materials--Report to legislature. • The Dept. and the office of administrative hearings shall insure that bilingual services are provided to non-English speaking applicants and recipients. The services shall be provided to the extent necessary to assure that non-English speaking persons are not denied or unable to obtain or maintain, services or benefits because of their inability to speak English.[147] • If the number of non-English speaking applicants or recipients sharing the same language served by any community service office client contact job classification equals or exceeds fifty percent of the average caseload of a full-time position in such classification, the department shall, employ bilingual personnel to serve such applicants or recipients.[148] • Regardless of the applicant or recipient caseload of any community service office, each community service office shall ensure that bilingual services required to supplement the community service office staff are provided through contracts with interpreters, local agencies, or other community resources. • Initial client contact materials shall inform clients in all primary languages of the availability of interpretation services for non-English speaking persons. Basic informational pamphlets shall be translated into all primary languages.[149] •

State / Status of Medicaid Managed care	Description of Medicaid Managed Care Language Requirements[150]
Washington continued	• To the extent all written communications directed to applicants or recipients are not in the primary language of the applicants or recipients, the department and the Office of Administrative Hearings shall include with the written communication in all primary languages of applicants or recipients describing the significance of the communication and specifically how the applicants or recipients may receive assistance in understanding, and responding to if necessary, the written communication. Dept. shall assure that sufficient resources are available to assist applicants and recipients in a timely fashion with understanding, responding to, and complying with the requirements of all such written communications.[151] "Primary languages" includes but are not limited to Spanish, , Cambodian, Chinese, Korean, Laotian, Vietnamese and sign language.[152]

APPENDIX C : State of California: Summary of Recommendations from the Cultural and Linguistic Requirements Subgroup and the National Health Law Program

❖ Cultural and Linguistic Requirements Subgroup

Summary of Major Recommendations[153]

1. When an ethnic group with limited English language capability is five percent (5 %) or more of the Medi-Cal managed care (AFDC) population in a County or totals 100 persons or more within the geographic service area of the plan, bilingual health services will be required at all key points of patient contact in addition to interpreter services, and bilingual information and programs (i.e., membership assistance, health education, plan coverage, satisfaction review).

2. Health Care Options presentations and materials should reflect the choices of managed care plans with accurate information about specific language capability of providers, and the culturally oriented services available in the respective plans.

3. The availability of traditional safety net providers, with proven track records in providing service to special populations, including federally qualified health centers and rural and community-based health centers, should be in the Health care options (HCO) and plan presentations. The relationship of these providers to the respective plans, when applicable, should be included in the presentations.

4. The proposed capitation rates should factor in the additional costs required to provide information and services in multiple languages. These additional cost include translated materials, interpreters, telephone translation services, training, etc.

5. To ensure community involvement, the plan should establish a community advisory committee, composed of enrolled Medi-Cal Beneficiaries and other community representatives. This committee should meet at least quarterly to review plan services and programs, their outcomes and any patient satisfaction or needs assessment/survey to further identify new services or modifications in current services.

6. For a fluent bilingual staff member, who is not medically trained, to qualify as an interpreter, this individual must complete an interpreter course of at least 4 hours that covers the terms and concepts associated with anatomy; diseases, particularly diseases more prevalent among the target population; supplies and prosthetic devices; medication; and cultural beliefs and practices.

7. Data by race, ethnicity and language should be collected, reported and analyzed on the enrollee population of the service area and on its enrollment/dis-enrollment practices, service utilization, service satisfaction, etc. Race, ethnicity and language categories will allow for the capture of data on ethnic subpopulations of African American, Asian/Pacific Islanders, Latinos and American Indians, as well as for racial group aggregates.

❖ National Health Law Program[154]

Summary of Recommendations for Culturally and Linguistically Appropriate Care

1. All materials and presentations (for marketing) should be developed in conjunction with and reviewed by independent literacy and linguistic experts before implementation. Materials, outreach and education strategies should be developed with the meaningful participation of consumers and consumer advocates.

2. DHS should ensure that the Medi-Cal application process and the HCO process include a mechanism for allowing all Medi-Cal eligible persons to identify the language in which they need to receive Medi-Cal managed care written materials and oral presentations. HCO should provide live, in-person presentations all primary languages. In addition, HCO should provide minimum written notice and access to a telephone translator for individuals who are not in any threshold primary language group.

3. Notices distributed by the local Department of Social Services (DPSS) informing applicant about HCO should be printed in languages other than English and should inform applicants clearly about the possible consequences of not filling out the Medi-Cal choice form.

4. Primary language thresholds should be determined by the number of both mandatory and voluntary enrollment of Medi-Cal eligibles in a plan service area (i.e. county) and within a zip code area. Limiting the count only to those in the mandatory enrollment group will make the threshold more difficult to meet, even though the plan could be serving numbers of individuals above the thresholds.

5. Plans should be required to provide all of the minimally required language access services from the outset of the contract. At the very least, DHS should impose a deadline for when these services must be in place. Plans not meeting the deadlines should be financially penalized. Leaving an open-ended time frame severely undermines the numerous and helpful protections gained for these groups of recipients.

6. Medical records should include reasons for refusal of translation services, including for example, "having to wait too long for the translator to arrive or be scheduled." Without this documentation, "refusals" will contain instances where the recipient was not provided sufficient access to the services.

7. Notices should be given to recipients on "refusal" of language access services for due process hearing purposes.

8. HCFA should not approve the waiver request until it has been amended to provide that:

- no recipient will be assigned to a plan or primary care site which has not certified that it has the ability to provide the appropriate language/cultural services;
- all materials and presentations are developed in conjunction with and reviewed by independent literacy and linguistic experts before implementation. Currently all notices, booklets and other materials must be improved substantially;
- all Medi-Cal beneficiaries receive materials explaining the proposed changes, how it will affect their future receipt of Medi-Cal services and how to retain fee-for-service eligibility in a language which they can understand;
- it includes a mechanism for allowing all Medi-Cal eligible persons to identify the language in which they need to receive Medi-Cal managed care written materials and oral presentations
- it provides for live, in-person presentations for all primary languages;
- it provides minimum information and or access to a telephone translator for individuals who are not in any threshold primary language group;
- notices concerning eligibility issues and actions affecting the provision of covered benefits are provided in designated primary languages to all individuals who indicate such a need;
- California demonstrates that it will be able to provide written notice concerning eligibility issues and actions affecting the provision of covered benefits in non-primary languages to all individuals who indicate such a need;
- California demonstrates a mechanism for identifying all people who need written notices provided in a language other than English.

Appendix D : Glossary of Terms

Cultural Competency: A process that requires individuals and systems to develop and expand their ability to know about, be sensitive to and have respect for cultural diversity. Essential to cultural competency is appropriate and effective communication which requires the willingness to listen and learn from members of diverse cultures and the provision of services and information in appropriate languages, at appropriate comprehension and literacy levels, and in the context of individuals' cultural health beliefs and practices.[155]

Interpretation: The process of explaining the meaning of one language, especially in speech and oral communication, into another language. In health services, interpretation involves conveying both the literal meaning and connotations of spoken and unspoken communication (i.e., body language, mannerism) to the health practitioner.[156]

Linguistically Appropriate Health Care: Health care services which are provided in a manner which is accessible and suitable for the population served. For health delivery systems, this means ensuring that a sufficient number of personnel or interpreters can directly communicate with the patient in his/her primary language at key points of contact.[157] It also involves the use of appropriately translated forms, educational materials, signs and posters.

Linguistic Isolation: Defined by the U.S. Census bureau as "no one in the household age 14 years or older can speak English 'well' or 'very well' ".

Managed Care Health Insurance Plans: The term "managed care" characterizes a wide range of health care plans that select a network of physicians and hospitals, negotiate reimbursement levels, and apply controls on the use of services. The types of these plans range from simple preferred provider organization networks (PPOs) to more tightly structured health maintenance organizations (HMOs). As the managed care industry evolves, the boundaries between different types of plans become increasingly blurred.[158]

Qualified Interpreter: A person who not only translates orally but also bridges the cultural gaps present in cross-cultural communication. Ideally, an interpreter should be someone who is trained in cross-cultural interpretation; trained in the health care field; proficient in the language of the client and that of professionals; and able to understand and respect the culture of the client and that of the health care professionals. Minimally, an interpreter must have training in medical terminology, an understanding of the significance of the particular health matter being discussed as well as an understanding of the importance of confidentiality.[159]

Translation: The process of putting words of one language into another language, particularly in written form. In health services, translation is used when converting written information from English-language medical forms, plan information brochures and other health-related materials into another language. Many materials, particularly health education materials, should not be translated without reviewing it first for cultural appropriateness.

END NOTES

[1] GAO. Medicaid: States Turn to Managed Care to Improve Access and Control Costs. HRD-93-46. March 1993.
[2] California Department of Health Services. Cultural and Linguistic Requirements Subgroup. "Recommended Standards for the Medi-Cal Managed Care Program". December 7, 1993.
[3] Project Hope. Center for Health Affairs. Medicaid Managed Care Program Access Requirements. Final Report. Submitted to: Prospective Payment Assessment Commission. March 27, 1995.
[4] State of Minnesota Office of Medicaid Managed Care. Patient Rights Under Managed Care. 1995.
[5] 42 U.S.C. Section 1396(b). These section 1915(b) waivers allowed HCFA to grant states exclusions from Medicaid program requirements concerning statewide implementation of the program, comparability of services, and recipient freedom-of-choice in plan selection.
[6] 42 U.S.C. Section 1315.
[7] GAO. Medicaid: States Turn to Managed Care to Improve Access and Control Costs. HRD-93-46. March 1993.
[8] CitiMatch at the University of Nebraska Medical Center. Changing the Rules: Medicaid Managed Care and Maternal Child Health in U.S. Cities. Special Report 1. July 1994.
[9] Horvath J, Kaye N. Medicaid Managed Care: A Guide for States. Portland, Me. National Academy for State Health Policy; 1995.
[10] GAO. Medicaid: States Turn to Managed Care to Improve Access and Control Costs. HRD-93-46. March 1993.
[11] GAO. Medicaid: States Turn to Managed Care to Improve Access and Control Costs. HRD-93-46. March 1993.
[12] Riley, Trish. Medicaid: The Role of the States. JAMA, July 19, 1995-Vol. 274, No. 3. Pages 267-270.
[13] GAO. Medicaid: States Turn to Managed Care to Improve Access and Control Costs. HRD-93-46. March 1993.
[14] Riley, Trish. Medicaid: The Role of the States. JAMA, July 19, 1995-Vol. 274, No. 3. Pages 267-270.
[15] Riley, Trish. Medicaid: The Role of the States. JAMA, July 19, 1995-Vol. 274, No. 3. Pages 267-270.
[16] US Bureau of the Census. Statistical Abstract of the US 1990 Census. 113th ed. Washington, DC: US Bureau of the Census.; 1993.
[17] Association of State and Territorial Health Officials. ASTHO Bilingual Health Initiative: Report and Recommendations. Washington, DC: Office of Minority Health; 1992.
[18] U.S. Department of Commerce. Bureau of the Census. We the Americans...Foreign Born. September 1993.
[19] U.S. Department of Commerce. Bureau of the Census. We the Americans...Foreign Born. September 1993.
[20] U.S. Department of Commerce. Bureau of the Census. We the Americans...Foreign Born. September 1993.
[21] U.S. Census Bureau. Census of Population and Housing. 1990.
[22] U.S. Census Bureau. Census of Population and Housing. 1990.
[23] National Public Health and Hospital Institute. Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals. March 1995.
[24] Woloshin, Steven,. Bickelly, Nina. Schwartz, Lisa. Gany, Francesca and Welch, Gilbert. Language Barriers in Medicine in the United States. JAMA, March 1, 1995-Vol. 273, No. 9.
[25] 42 U.S.C. / 2000d
[26] 414 U.S. 563, 1974.
[27] 414 U.S. 563, 1974.
[28] Chang, Caroline J. Regional Manager, Region 1 of the Department of Health and Human Services, Office for Civil Rights. Letter of Findings Re: Complaint No. 01-86-3004 to Rhode E. Perry, Executive Director, Health Service Incorporated, Rhode Island. September 26, 1986.
[29] Application of Title VI in health and welfare programs: effect on agency employment practices (national origin). Title VI Compendium. 1971;1:19-24.
[30] Woloshin, Steven,. Bickelly, Nina. Schwartz, Lisa. Gany, Francesca and Welch, Gilbert. Language Barriers in Medicine in the United States. JAMA, March 1, 1995-Vol. 273, No. 9.
[31] Report of the HHS Civil Rights Review Team. Washington, DC: US Dept. of Health and Human Services, Office for Civil Rights. 1993.
[32] National Public Health and Hospital Institute. Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals. March 1995.
[33] Association of Asian Pacific Community Health Organizations. "Multilingual/Multicultural Eligibility Assistance Project: Report and Recommendations." Funded by the Office of Minority Health: U.S. Department of Health and Human Services. Oakland: Unpublished, October, 1993.
[34] Association of Asian Pacific Community Health Organizations. "Multilingual/Multicultural Eligibility Assistance Project: Report and Recommendations." Funded by the Office of Minority Health: U.S. Department of Health and Human Services. Oakland: Unpublished, October, 1993.

[35] National Public Health and Hospital Institute. Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals. March 1995.
[36] National Public Health and Hospital Institute. Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals. March 1995.
[37] Woloshin, Steven,. Bickelly, Nina. Schwartz, Lisa. Gany, Francesca and Welch, Gilbert. Language Barriers in Medicine in the United States. JAMA, March 1, 1995-Vol. 273, No. 9.
[38] National Public Health and Hospital Institute. Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals. March 1995.
[39] National Public Health and Hospital Institute. Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals. March 1995.
[40] Association of Asian Pacific Community Health Organizations. "Culturally Competent Health Service Delivery Under Managed Care for Asians and Pacific Islanders." Oakland: 1994.
[41] GAO. Medicaid: States Turn to Managed Care to Improve Access and Control Costs. HRD-93-46. March 1993.
[42] Please Note: This chart only contains the most important aspects of state requirements; some states do have more detailed requirements for their contractors. Most of the information cited in this table was provided by the Medicaid managed care contact person in each state unless otherwise noted.
[43] State of California. Medic-Cal Managed Care Division. Response to AAPCHO Survey. Larry Lucero, September, 1995.
[44] California Medi-Cal Managed Care Request for Application. September 30, 1994.
[45] California Medi-Cal Managed Care Request for Application. September 30, 1994.
[46] State of Hawaii. Department of Health Services. Med-Quest Division. Response to AAPCHO Survey. Winifred Odo. September, 1995.
[47] Illinois Department of Public Aid. Response to AAPCHO Survey. Dean Schott. Chief, Office of Communications. July 19, 1995.
[48] Massachusetts Division of Medical Assistance, Benefit Plans. Response to AAPCHO Survey. Meryl Friedman, Director HMO Program. August, 1995.
[49] Project Hope. Center for Health Affairs. Medicaid Managed Care Program Access Requirements. Final Report. Submitted to: Prospective Payment Assessment Commission. March 27, 1995.
[50] Minnesota Department of Human Services. Response to AAPCHO Survey. Bill Novak. September, 1995.
[51] Project Hope. Center for Health Affairs. Medicaid Managed Care Program Access Requirements. Final Report. Submitted to: Prospective Payment Assessment Commission. March 27, 1995.
[52] Office of Minority Health; Newsletter, 1995.
[53] New Mexico Human Services Department, Medical Assistance Division. Office of Managed Care. Response to AAPCHO survey. CaraLyn Banks, July, 1995.
[54] New York State Department of Health. Office of Managed Care. Response to AAPCHO Survey. Barbara Frankel. September, 1995.
[55] Project Hope. Center for Health Affairs. Medicaid Managed Care Program Access Requirements. Final Report. Submitted to: Prospective Payment Assessment Commission. March 27, 1995.
[56] Oregon Dept. Of Human Resources. Office of Medical Assistance Programs. Oregon Health Plan Administrative Rules: January 1, 1995.
[57] A non-English speaking household is a household that does not have an adult OMAP Member who is capable of communicating in English.
[58] Project Hope. Center for Health Affairs. Medicaid Managed Care Program Access Requirements. Final Report. Submitted to: Prospective Payment Assessment Commission. March 27, 1995.
[59] Texas Dept. Of Health: Bureau of Managed Care. Response to AAPCHO Survey. Christine Fargo, Policy Analyst. July, 1995.
[60] Texas Dept. of Health. Bureau of Managed Care. 1995.
[61] Health Care Financing Administration. Managed Care Marketing Guidelines for States. 1994.
[62] Texas Dept. of Health. Bureau of Managed Care. 1995.
[63] Texas Dept. of Health. Bureau of Managed Care. 1995.
[64] Washington Medical Assistance Administration. Division of Managed Care & Quality Assurance. Excerpts from Managed Care Program Contract. May, 1995.
[65] Washington Medical Assistance Administration. Division of Managed Care & Quality Assurance. CITESEARCH May, 1995.
[66] Washington Medical Assistance Administration. Division of Managed Care & Quality Assurance. CITESEARCH May, 1995.
[67] State of Washington, Medical Assistance Administration, Dept. Of Social and Health Services. Response to AAPCHO Survey. Personal Communication with D. Andrea Davis, Program Manager. August, 1995.

[68] National Health Law Program. Consumer Analysis and Recommendations on the California Department of Health Services Section 1915(b) Capitated Waiver Request for the Expansion of the Medi-Cal Managed Care Program "Two-Plan Model". September 20, 1995.
[69] Department of Social and Health Services. State of Washington. Managed Care Contract. (1995).
[70] Texas Dept. Of Health: Bureau of Managed Care. Response to AAPCHO Survey. Christine Fargo, Policy Analyst. July, 1995.
[71] Personal Communication . Barbara Marquez. Assistant Chief. Office of Multicultural Health. Department of Health Services. State of California. January 11, 1996.
[72] State of California. Medic-Cal Managed Care Division. Response to AAPCHO Survey. Larry Lucero, September, 1995.
[73] State of Hawaii. Department of Health Services. Med-Quest Division. Response to AAPCHO Survey. Winifred Odo. September, 1995.
[74] Illinois Department of Public Aid. Response to AAPCHO Survey. Dean Schott, Chief, Office of Communications. July 19, 1995.
[75] Project Hope. Center for Health Affairs. Medicaid Managed Care Program Access Requirements. Final Report. Submitted to: Prospective Payment Assessment Commission. March 27, 1995.
[76] Project Hope. Center for Health Affairs. Medicaid Managed Care Program Access Requirements. Final Report. Submitted to: Prospective Payment Assessment Commission. March 27, 1995.
[77] Massachusetts Division of Medical Assistance, Benefit Plans. Response to AAPCHO Survey. Meryl Friedman, Director HMO Program. August, 1995.
[78] Massachusetts Division of Medical Assistance, Benefit Plans. Response to AAPCHO Survey. Meryl Friedman, Director HMO Program. August, 1995.
[79] Project Hope. Center for Health Affairs. Medicaid Managed Care Program Access Requirements. Final Report. Submitted to: Prospective Payment Assessment Commission. March 27, 1995.
[80] Minnesota Department of Human Services. Response to the AAPCHO Survey. Bill Novak, September, 1995.
[81] New Mexico Human Services Department, Medical Assistance Division. Office of Managed Care. Response to AAPCHO survey. CaraLyn Banks, July, 1995.
[82] New York State Department of Health. Office of Managed Care. Response to AAPCHO Survey. Barbara Frankel. September, 1995.
[83] Project Hope. Center for Health Affairs. Medicaid Managed Care Program Access Requirements. Final Report. Submitted to: Prospective Payment Assessment Commission. March 27, 1995.
[84] Project Hope. Center for Health Affairs. Medicaid Managed Care Program Access Requirements. Final Report. Submitted to: Prospective Payment Assessment Commission. March 27, 1995.
[85] Oregon Department of Human Resources. Office of Medical Assistance Programs. Response to AAPCHO Survey. Brenda Goldstein. September, 1995.
[86] Oregon Department of Human Resources. Office of Medical Assistance Programs. Response to AAPCHO Survey. Brenda Goldstein. September, 1995.
[87] Texas Dept. Of Health: Bureau of Managed Care. Response to AAPCHO Survey. Personal Communication with Christine Fargo, Policy Analyst. July, 1995.
[88] Medical Assistance Administration, Dept. Of Social and Health Services. Washington. Response to AAPCHO Survey. Personal Communication with D. Andrea Davis, Program Manager. August, 1995.
[89] National Public Health and Hospital Institute. Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals. March 1995.
[90] National Public Health and Hospital Institute. Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals. March 1995.
[91] National Public Health and Hospital Institute. Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals. March 1995.
[92] National Public Health and Hospital Institute. Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals. March 1995.
[93] National Public Health and Hospital Institute. Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals. March 1995.
[94] National Public Health and Hospital Institute. Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals. March 1995.
[95] National Public Health and Hospital Institute. Interpretation and Translation Services in Health Care: A Survey of US Public and Private Teaching Hospitals. March 1995.
[96] State of California. Medi-Cal Managed Care Division. Response to AAPCHO Survey. Larry Lucero, September, 1995.

[97] State of Hawaii. Department of Health Services. Med-Quest Division. Response to AAPCHO Survey. Winifred Odo. September, 1995.
[98] State of Hawaii. Department of Health Services. Med-Quest Division. Response to AAPCHO Survey. Winifred Odo. September, 1995.
[99] Illinois Department of Public Aid. Response to AAPCHO Survey. Dean Schott, Chief, Office of Communications. July 19, 1995.
[100] Minnesota Dept. Of Human Services. Health Care Administration. Managed Care Division. Description of Rate Setting Methodology used for 1995 and 1996.
[101] New Mexico Human Services Department, Medical Assistance Division. Office of Managed Care. Response to AAPCHO survey. CaraLyn Banks, July, 1995.
[102] New York State Department of Health. Office of Managed Care. Response to AAPCHO Survey. Barbara Frankel. September, 1995.
[103] Oregon Department of Human Resources. Office of Medical Assistance Programs. Response to AAPCHO Survey. Brenda Goldstein. September, 1995.
[104] Texas Dept. Of Health: Bureau of Managed Care. Response to AAPCHO Survey. Christine Fargo, Policy Analyst. July, 1995.
[105] The $75 is assumed to be the going rate for interpreters (including a flat fee with travel time + two hours minimum per encounter). There is some variance among types of appointments. Source: Minnesota Department of Human Services. Personal Communication with Bill Novak. Consultant. December, 21, 1995.
[106] California Medi-Cal Managed Care Request for Application. September 30, 1994.
[107] Minnesota Department of Human Services; Health Care Administration; Managed Care Division. Rate Setting Methodology used for 1995 and 1996.
[108] State of California. Medi-Cal Managed Care Division. Response to AAPCHO Survey. Larry Lucero, September, 1995.
[109]
[110] Riley, Trish. Medicaid: The Role of the States. JAMA, July 19, 1995-Vol. 274, No. 3. Pages 267-270.
[111] Association of Asian Pacific Community Health Organizations. The Language Access Project. Final Report. Funded by the Office of Minority Health. Forthcoming.
[112] Please see Appendix C for the "Medi-Cal Managed Care RFA Section 9.10 Cultural and Linguistic Requirements".
[113] California Medi-Cal Managed Care Request for Application. September 30, 1994.
[114] Ethnicities to be reported: African American, Alaskan/American Indian, Amerasian, Asian/Pacific, Cambodian, Caucasian, Chinese, Filipino, Guamanian, Hawaiian, Hispanic, Japanese, Korean, Laotian, Samoan, Vietnamese.
[115] Arabic, Armenian, Cambodian, Cantonese, Farsi, Hmong, Korean, Lao, Mandarin, Mien, Russian, Samoan, Spanish, Tagalog and Vietnamese.
[116] State of Hawaii Dept. Of Human Services. Response to AAPCHO Survey. July 11, 1995.
[117] State of Hawaii Dept. Of Human Services. Response to AAPCHO Survey. Winifred Odo July 11, 1995.
[118] State of Hawaii Dept. Of Human Services. Response to AAPCHO Survey. Winifred Odo. July 11, 1995.
[119] Illinois Department of Public Aid. Response to AAPCHO Survey. Dean Schott, Chief of Communications. July 19, 1995.
[120] Illinois Department of Public Aid. Response to AAPCHO Survey. Dean Schott, Chief of Communications. July 19, 1995.
[121] Illinois Department of Public Aid. Response to AAPCHO Survey. Dean Schott, Chief of Communications. July 19, 1995.
[122] Massachusetts Division of Medical Assistance, Benefit Plans. Response to AAPCHO Survey. Meryl Friedman, Director HMO Program. August, 1995.
[123] Project Hope. Center for Health Affairs. Medicaid Managed Care Program Access Requirements. Final Report. Submitted to: Prospective Payment Assessment Commission. March 27, 1995.
[124] Massachusetts Division of Medical Assistance, Benefit Plans. Response to AAPCHO Survey. Meryl Friedman, Director HMO Program. August, 1995.
[125] Massachusetts Division of Medical Assistance, Benefit Plans. Response to AAPCHO Survey. Meryl Friedman, Director HMO Program. August, 1995.
[126] Massachusetts Division of Medical Assistance, Benefit Plans. Response to AAPCHO Survey. Meryl Friedman, Director HMO Program. August, 1995.
[127] Please Note: This chart only contains the most important aspects of state requirements; some states do have more detailed requirements of their contractors.
[128] Minnesota Dept. Of Health. Minnesota's Prepaid Medical Assistance Program (PMAP). Contract Language; 1995.
[129] Minnesota Dept. Of Health. Minnesota's Prepaid Medical Assistance Program (PMAP). Contract Language; 1995.
[130] Minnesota Dept. Of Health. Minnesota's Prepaid Medical Assistance Program (PMAP). Contract Language; 1995.

[131] Project Hope. Center for Health Affairs. Medicaid Managed Care Program Access Requirements. Final Report. Submitted to: Prospective Payment Assessment Commission. March 27, 1995.
[132] Office of Minority Health. Newsletter, 1995.
[133] Please Note: This chart only contains the most important aspects of state requirements; some states do have more detailed requirements of their contractors.
[134] New York State Department of Health. Office of Managed Care. Response to AAPCHO Survey. Barbara Frankel December, 1995.
[135] Please Note: This chart only contains the most important aspects of state requirements; some states do have more detailed requirements of their contractors.
[136] Oregon Dept. Of Human Resources. Office of Medical Assistance Programs. Oregon Health Plan Administrative Rules: January 1, 1995.
[137] Project Hope. Center for Health Affairs. Medicaid Managed Care Program Access Requirements. Final Report. Submitted to: Prospective Payment Assessment Commission. March 27, 1995.
[138] Oregon Department of Human Resources. Office of Medical Assistance Programs. Response to AAPCHO Survey. Brenda Goldstein. September, 1995.
[139] Oregon Department of Human Resources. Office of Medical Assistance Programs. Response to AAPCHO Survey. Brenda Goldstein. September, 1995.
[140] Texas Dept. of Health. Bureau of Managed Care. 1995.
[141] Health Care Financing Administration. Managed Care Marketing Guidelines for States. 1994.
[142] Texas Dept. of Health. Bureau of Managed Care. 1995.
[143] Please Note: This chart only contains the most important aspects of state requirements; some states do have more detailed requirements of their contractors.
[144] Texas Dept. of Health. Bureau of Managed Care. 1995.
[145] Washington Medical Assistance Administration. Division of Managed Care & Quality Assurance. Excerpts from Managed Care Program Contract. May, 1995.
[146] State of Washington, Medical Assistance Administration, Dept. Of Social and Health Services. Response to AAPCHO Survey. Personal Communication with D. Andrea Davis, Program Manager. August, 1995.
[147] Washington Medical Assistance Administration. Division of Managed Care & Quality Assurance. CITESEARCH May, 1995.
[148] Washington Medical Assistance Administration. Division of Managed Care & Quality Assurance. CITESEARCH May, 1995.
[149] Washington Medical Assistance Administration. Division of Managed Care & Quality Assurance. CITESEARCH May, 1995.
[150] Please Note: This chart only contains the most important aspects of state requirements; some states do have more detailed requirements of their contractors.
[151] Washington Medical Assistance Administration. Division of Managed Care & Quality Assurance. CITESEARCH May, 1995.
[152] Washington Medical Assistance Administration. Division of Managed Care & Quality Assurance. CITESEARCH May, 1995.
[153] Cultural and Linguistic Requirements Subgroup. Recommended Standards for the Medi-Cal Managed Care Program. California Department of Health Services. December 7, 1995.
[154] National Health Law Program. Consumer Analysis and Recommendations on the California Department of Health Services Section 1915(b) Capitated Waiver Request for the Expansion of the Medi-Cal Managed Care Program "Two-Plan Model". September 20, 1995.
[155] California Cultural Competency Task Force. Recommendations for the Medi-Cal Managed Care Program. Submitted to the California Department of Health Services. February 8, 1994.
[156] California Department of Health Services. Cultural and Linguistic Requirements Subgroup. Recommended Standards for the Medi-Cal Managed Care Program. December 7, 1993.
[157] Association of Asian Pacific Community Health Organizations. "Multilingual/Multicultural Eligibility Assistance Project: Report and Recommendations." Funded by the Office of Minority Health. U.S. Department of Health and Human Services. Oakland: Unpublished, October, 1993.
[158] The Commonwealth Fund. Patient Experiences with Managed Care: A Survey. July 19, 1995.
[159] Elizabeth Randall-David. "Strategies for Working with Culturally Diverse Communities and Clients." 1992. As cited by California Cultural Competency Task Force. Recommendations for the Medi-Cal Managed Care Program. Submitted to the California Department of Health Services. February 8, 1994.

Association of Asian Pacific
Community Health Organizations
1212 Broadway, Suite 730
Oakland, CA 94612
(510) 272-9536
(510) 272-0817 fax